

Add a Person Form

To add people in your household to Healthy Families

Instructions

- Use this form for any people in your home you would like to add to Healthy Families. To add more than 4 people, copy this form.
- Use this form for unborn children who are due to be born within 90 days. Send with this form a copy of your pregnancy certificate that shows the estimated date of delivery. After a baby is born, mail a copy of the birth document to Healthy Families within 30 days. Coverage for the baby will start 13 days after we get the document.
- For each person who is a U.S. citizen or national, you must **send a copy of a birth certificate within 2 months.** For people who are not U.S. citizens or nationals, you must send **proof of immigration status within 2 months.**

Questions?

If you have any questions about the form, call Healthy Families: **1-866-848-9166**, Monday to Friday, 8 a.m. to 8 p.m., or on Saturday from 8 a.m. to 5 p.m.

The call is free.

Family Member Number:

Poople to add -

Date of birth (or expected date)

Birth place (California county, other state or other country)

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	First name								
Name →	Middle name								
	Last name			•		•			
Diath	First name								
Birth name ⇒ (if different from name above)	Middle name								
mom name abovej	Last name								
Address	Street								
Address ⇒ (if different from applicant's)	City								
потт аррисантя)	Zip Code								
Relationship to ap	plicant								
Sex		☐ Male	☐ Female						
***************************************		4							

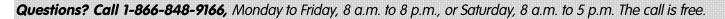
Questions about these persons continue on next page.

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People to add, continued ⇒		Person 1		Person 2			Person 3			Person 4						
Ethnicity What is the ethnic (cultural) background of each person?		White Hispanic Black/African American Asian American Indian Alaskan Native Filipino Amerasian Chinese Cambodian Japanese Samoan Asian Indian Hawaiian Guamanian Laotian Vietnamese Korean Other		White Hispanic Black/African American Asian American Indian Alaskan Native Filipino Amerasian Chinese Cambodian Japanese Samoan Asian Indian Hawaiian Guamanian Laotian Vietnamese Korean Other			White Hispanic Black/African American Asian American Indian Alaskan Native Filipino Amerasian Chinese Cambodian Japanese Samoan Asian Indian Hawaiian Guamanian Laotian Vietnamese Korean Other			White Hispanic Black/African American Asian American Indian Alaskan Native Filipino Amerasian Chinese Cambodian Japanese Samoan Asian Indian Hawaiian Guamanian Laotian Vietnamese Korean Other						
U.S citizen or national?		□ Y	⁄es	☐ No		Yes		No		Yes		No		Yes	<u> </u>	V O
If no, write date of entry into U.S.																
Social Security Number have to write this)	er: (You do not															
Mother's name →	First name															
	Last name															
Does the mother live in the home?		<u> </u>	⁄es	☐ No		Yes		No		Yes		No		Yes	1	V O
Father's name → First name Last name																
Does the father live in the home?		Y	⁄es	☐ No		Yes		No		Yes		No		Yes	1	V O
If the person earns in much per month? See the Family Members a brochure about what to list	nd Income	\$ From where?		\$ From where?			\$ From where?			\$ From where?						
Does this person have no-cost Medi-Cal? If yes, give date coverage will end		☐ Y	⁄es	☐ No		Yes		No		Yes		No		Yes	1	Vo

Questions about these persons continue on next page.



Add a Person Form, Page 3

People to add, <i>continued</i> →	Person 1	Person 2	Person 3	Person 4
	Yes No	Yes No	☐ Yes ☐ No	Yes No
Did this person have health insurance from an employer in the last 90 days? If yes, check the main reason why insurance stopped.	lost or changed job moved, no insurance available employer ended benefits to all employees COBRA coverage ended reached maximum coverage of benefits death, legal separation or divorce other:	ended reached maximum coverage of benefits death, legal separation or divorce	lost or changed job moved, no insurance available employer ended benefits to all employees COBRA coverage ended reached maximum coverage of benefits death, legal separation or divorce other:	benefits to all employees
Write date insurance stopped.				

Name of adult	Relationship to applicant	Relationship to children	Gross income amount (income before taxes)	How often is the person paid?
	Applicant		\$ Send proof of income	once every week every two weeks twice a month once a month
			\$ Send proof of income	once every week every two weeks twice a month once a month

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Expenses

→ Applicant Signature:___

Permission to share information with the following person: I give permission for the Healthy Families Program and Medi-Cal Program to give inform telephone about the status of this application to a Certified Application Assistant of the En organization identified. This permission will end on the date the program mails the result determination on this application. Name:	nrollment Entity
I give permission for the Healthy Families Program and Medi-Cal Program to give inform telephone about the status of this application to a Certified Application Assistant of the Erorganization identified. This permission will end on the date the program mails the resu	nrollment Entity
Permission to forward Add a Person Form to Medi-Cal: If this person/child is ineligible for He that this form be forwarded to the county and treated as a Medi-Cal application. I declare un that the information on this form is true and correct to the best of my knowledge and belief. F Security numbers of anyone applying for full scope Medi-Cal benefits. Applicant Signature: Date:	der penalty of perjury
I, the applicant, certify that the information provided is true and correct. I understand that add members may result in a higher monthly premium. Applicant Signature: Date:	ling additional family
Is the applicant or anyone else in the home pregnant? Yes No If yes, name?	
For each working parent, we will deduct up to \$90 for work-related expenses.	Send proof of expense
Monthly court ordered child support you pay.	\$
Monthly court ordered alimony you pay.	\$ Send proof of expense
Disabled dependent care expenses you pay each month. The maximum amount allowed is \$175 per person receiving care.	\$ Send proof of expense
	\$ Send proof of expense
Childcare expenses you pay each month for children <u>age 2 and over</u> . The maximum amount allowed is \$175 per child.	Φ.

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Date: